

Lawrence Osman, M.D.
Board-certified Dermatologist
Dermatology • Safe Liposuction

PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____ Prefer to be called: _____
 First Middle Last

Address: _____
 Street/Apt# City State Zip

Phone: _____ Cell: _____ Birth Date: _____

Male Female Single Married Divorced Widow

Is it okay to leave messages at: Home Work Cell

Is it okay to discuss your medical condition with any member of your household? Yes No

If no, who? _____

Other family members seen in office: _____

Who referred you? _____ Primary Care Physician: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If you are a minor... Father/Guardian: _____ Phone: _____

Mother/Guardian: _____ Phone: _____

Only Complete If You Are Not The Primary Insured

1. Primary Insurance: _____ Primary Insured's Name _____

Primary Insured's Relationship to Patient: Spouse Father Mother

Primary Insured's Birth Date: _____

2. Secondary Insurance: _____ Primary Insured's Name _____

Primary Insured's Relationship to Patient: Spouse Father Mother

Primary Insured's Birth Date: _____

Are you interested in receiving EMAILS about NEW SERVICES and PROMOTIONS? Yes No

If so, please provide your email address: _____

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize payment of insurance benefits directly to Lawrence Osman, M.D.

Date

Signature of Patient or Parent if a Minor

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PATIENT HISTORY FORM

Name: _____ **Date:** _____

Reason for Visit: What is the main reason for your visit? Rash Growth/Mole Acne
 Other _____

Where is it located? _____

How long has it been there? _____

Does it itch, hurt, bleed easily, or other _____
(Check all that apply.)

Have you used any form of treatment and has it helped?

Do you have now or have you recently had:

Itchy eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rapid heart beat (palpitations)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Noticeable intolerance to hot or cold environments	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has a doctor ever advised you to take antibiotics prior to dental procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Allergies to Medications:

Please list all known **allergies to medications** or write "none": _____

Medications:

Please list all medications you are currently taking or write "none": _____

Medical History:

Please list all current and past medical problems or write "none": _____

Optional: Did you know we offer a variety of cosmetic procedures?

Please circle the procedure(s) you would like to learn more about: Botox, Restylane, Juvederm, liposuction, lasers

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PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Lawrence Osman, M.D., will use your medical information for the following:

TREATMENT: Includes providing your medical records to consulting clinicians and insurance companies.

PAYMENT: Includes providing your medical records to insurance companies requesting part or all of your medical records to pay the claim.

HEALTH CARE OPERATIONS: Includes any others involved in your healthcare.

The complete Private Policy Notices of Lawrence Osman, M.D., are available for your review. If you would like to obtain a copy, please ask the front office, and we will gladly provide one for you.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's or Legal Guardian's Name

Patient's Date of Birth

Witness

Date